

Mr & Mrs J Fieldhouse

Stella House Residential Care Home

Inspection report

Cobblers Lane
Pontefract
West Yorkshire
WF8 2SS

Tel: 01977600247
Website: www.stellahousecarehome.co.uk

Date of inspection visit:
16 March 2017
20 March 2017

Date of publication:
21 June 2017

Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Inadequate 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

This inspection took place on 16 and 20 March 2017. The home was previously inspected in August 2016 and was in breach of the regulations in relation to good governance, consent and safe care and treatment. We asked the provider to take action to make improvements and at this inspection we checked to see the actions had been completed. We found some improvements had been made but there were still areas which had not attained the required standard of care.

Stella House is registered to provide accommodation and personal care for up to 40 people. There were 32 people living there at the time of our inspection including nine people staying on a temporary basis. There was no registered manager at the service during our inspection. The previous registered manager had not been at the service since July 2016 but they had not yet deregistered. A new manager had been appointed and had been at the home at the last inspection in August 2016 on a temporary basis. They told us they had accepted the position of registered manager and would commence the registration process. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Staff had been trained and understood how they should ensure people were safeguarded against abuse and the procedure to follow to report any incidents. However, there was a culture of poor risk management at the home, so although staff had been trained in safeguarding people from abuse, the systems and processes were not adequate to support safe care and treatment.

Risks to the health and safety of people using the service were not always thoroughly assessed and effectively managed and this placed people at risk of otherwise avoidable harm. For example, the hot water from the taps accessible to vulnerable people in bedrooms and communal bathrooms were over the acceptable range, and radiators were scalding. This had not been highlighted by staff or management as an issue. Once we highlighted the issue the registered provider acted immediately to rectify the issue, but their own systems had not picked this up.

Medication was administered appropriately and all staff who administered medication had received training and had been assessed as competent to administer medicines. We found some minor issues with the management of medicines such as not dating eye drops on opening and not storing these in the refrigerator. In addition, not all 'as and when required' medicines had a protocol in place to guide staff on when to administer.

People at risk of malnutrition or dehydration did not have robust care plans and monitoring records in place. This had been an issue at a previous inspection and improvements made at the last inspection had not been sustained or improved further.

Staff undertook an induction when they first started working in the home and shadowed more experienced staff to gain confidence in their role. Staff completed the Care Certificate and their competencies were signed off by management.

The home was compliant to the Mental Capacity Act 2005 Deprivation of Liberty Safeguards (DoLS). The home had a record of registered powers of attorney and who could consent on behalf of people at the home. At our last inspection we found staff had signed consent forms on behalf of people when they did not have the lawful authority to do so. There were improvements in this area but we still found care files without a record of written consent.

We found all the staff to be caring in their approach to the people who lived at the home and staff treated people with dignity and respect. Staff knew the people they supported very well and were keen for people to feel they were at home. Staff recognised the importance of promoting and maximising independence in people's everyday lives and could evidence how this approach had led to improvements in people's abilities.

At our last inspection we found care records did not always represent an accurate picture of people's support needs. The home had put in an action plan to address these shortfalls but we found similar issues with risk assessments, care plans and food and fluid charts which were not always accurate or up to date at this inspection. This meant that staff did not have access to complete and contemporaneous records in respect of each person using the service, which potentially put people at risk of harm. Improvements found at the last inspection had not been sustained and there was evidence to support recording practices were still an issue.

Improvement in the audits undertaken at the service that we had found at our last inspection had not been sustained and demonstrated the service was not rigorously monitoring and improving the quality of the service provided. Robust audits and management oversight would have highlighted issues with poor recording, poor assessment of risk, environmental issues and that the home was not meeting its own goals in terms of actions which were required to meet the fundamental standards of care.

We found several breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to safe care and treatment, record keeping, meeting people's nutritional and hydration needs and good governance. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate ●

The service was not safe.

The assessment and management of risk was not adequate and placed people at risk of avoidable harm.

We found issues with the management of medicines which had not been rectified since our last inspection.

Records showed recruitment checks were carried out to ensure suitable staff were recruited to work with people at the service.

Is the service effective?

Requires Improvement ●

The service was not always effective.

People enjoyed the food and told us they were offered a choice of two options. Not everyone who was at risk of malnutrition and dehydration had care plans in place detailing their requirements and the records did not confirm they had received adequate nutrition and hydration consistently.

The service had appropriately referred to the local authority where a person was deprived of their liberty under the Mental Capacity Act 2005 (MCA) Deprivation of Liberty Safeguards.

Staff had been trained, supervised and appraised to ensure they developed in their role.

Is the service caring?

Good ●

The service was caring.

People told us staff were caring, compassionate and kind.

Staff knew how to ensure privacy, dignity and confidentiality were protected at all times.

Staff were polite and respectful in their interactions with people. The service supported people to maintain their faith requirements.

Is the service responsive?

The service was not always responsive.

Some care plans contained information to enable staff to deliver person centred care such as people's preferences and views. But other care plans did not contain sufficient information to enable staff to provide responsive care.

The activities coordinator was covering care tasks whilst there was a shortage of staff which meant the activity programme to provide meaningful occupation, was only available when staffing levels were adequate.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

We found the audits at the home had not been robust and had not identified issues or driven up and sustained improvements.

Systems and processes had failed to ensure the safety and welfare of people living at the home and there was a culture of poor risk management.

Staff told us the manager was supportive.

Requires Improvement ●

Stella House Residential Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 16 and 20 March 2017. The inspection team consisted of two adult social care inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

The provider was not asked to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We used a number of different methods to help us understand the experiences of people who lived in the home. Before our inspection, we reviewed the information and intelligence we had received about the service including the statutory notifications, enquiries and safeguarding referrals. We contacted commissioners of services provided at this home and the local authority safeguarding team. We also contacted other stakeholders such as the police, the fire service and infection control services.

We spoke with seven people who lived at Stella House and four relatives. We spoke with the registered provider, the area manager, the manager, the assistant manager, and a team leader. We also spoke with the cook and the activities coordinator.

We observed care interactions, including in the communal and dining areas. We reviewed four care records in detail of people living at Stella House and four medication administration records. We also looked at records relating to the maintenance of the home and servicing records.

Is the service safe?

Our findings

We looked at how the service managed risk to ensure people living at Stella House were safe as this had been an issue at our last inspection. At this inspection we found a continued breach in Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to safe care and treatment.

We had concerns that not all risks to people had been assessed and minimised. The registered provider used standardised risk assessments such as the Waterlow scale, which is a tool to assist staff to assess the risk of a person developing a pressure ulcer and 'MUST' (Malnutrition Universal Screening Tool) which is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition. We reviewed one person's care file and found they had lost 8kg since November 2016. However, although they were being weighed regularly, the dietician had not been contacted until February 2017 and their nutrition care plan had not been evaluated for three months, which demonstrated the service was not assessing the risk of malnutrition effectively for this person and to ensure a care plan was put in place to reverse this weight loss.

Whilst people were seated in communal areas, we observed staff removing some people's walking aids and putting them in a bundle at the edge of the room. However, we saw one person who required a walking aid get up and walk without their aid. There were no staff in the vicinity and the inspection team intervened as this person was unsteady on their feet without the use of their walking aid. Moving mobility aids away from people in an area where staff were not present increased the risk that people would attempt to mobilise without their equipment and without the required assistance and increase their risk of falls.

The registered provider utilised a comprehensive falls risk assessment but as there had been a very high number of falls in January and February 2017, it was not clear that the assessments and risk reduction measures identified had been effective. After each fall an accident and incident form was completed by staff and passed to the manager for review. The accident and incident forms had been placed into people's files once the manager had reviewed them which made it difficult for us to see how they had been analysed. However, the manager collated the information for us from individual care files for the previous month. On review of this information, we found a deeper analysis was required with information such as where staff were when the person had fallen to identify whether it was a staff deployment issue. Following our inspection the manager sent us information in relation to falls in March 2017 which detailed how they had improved the information collated post incident which enabled an improved analysis to determine trends and themes. This also showed that people who had multiple falls had been referred to the Wakefield Vanguard for expert guidance and advice. This dedicated team of health and care professionals' proactively monitor people to make sure care for potential health problems is offered as early as possible. They support and build the skills and confidence of care home staff through training and education.

We had concerns about the temperature of the water emerging from the hot taps in some bedrooms and communal bathrooms. This exceeded the safe temperature recommendation for care homes. We brought this to the attention of the area manager who agreed to act upon this immediately and a plumber was

contracted to carry out the work the next day. We asked staff whether they checked the temperature of the water before people were assisted into the bath, and were told this was not the usual practice. The assistant manager searched for a thermometer to test the temperature of the bath but when one was found this was not working. Therefore the registered provider could not guarantee the water temperatures in all basins, showers and baths was at a safe level and the home could not guarantee there was a safe system in place. We found some of the radiators in the home were scalding to touch and one which had a thermostat set to come on when the temperature at the lowest point, was too hot to touch which showed there was an issue with the heat control. The area manager agreed to ensure a solution was actioned once the issue had been pointed out. Ensuring vulnerable people are protected from scalding is an essential health and safety requirement and systems should be in place to monitor this constantly. Controls should be adequately maintained to ensure they remain effective. In other rooms in the home, hot water was lukewarm and did not reach a comfortable temperature. This demonstrated systems at the home were not effective to ensure the safety of the people living there.

We were concerned about how some risks were managed. For example, at the start of our inspection on the first day, one person's prescribed thickener had been left out in their bedroom. NHS England issued a Patient Safety Alert in 2015 in relation to the risk of death from asphyxiation by accidental ingestion of fluid/food thickening powder if left in reach of people living in a care home. On the second day of inspection we observed a 'thick and easy' jar of thickener on the tea trolley, with no name on it to determine who this was for. This was raised with the manager who agreed to ensure thickeners were stored to ensure there was no risk to the people living in the home.

The manager told us the assistant manager completed a Personal Emergency Evacuation Plan (PEEP) to enable staff to assist people to evacuate the building if necessary. In one file we reviewed the PEEP which included the following information, 'Must be aided and reassured by one person to walk out of the exit. May require wheelchair at times'. This did not reflect their fluctuating abilities or the fact they were hoisted at certain times during the day. In another person's file their PEEP had not been updated and referred to their previous bedroom based on the first floor. This meant there was no accurate record of how to support people in the event of an emergency evacuation.

The registered provider utilised a moving and handling risk assessment and care plan which was required to promote the safe handling of people at the service. However, we found the information lacked detailed recording of the method staff were to follow to safely move the person and not all the equipment needed to do this had been identified in the plan. For example, one person used a special seating system to maintain their safety but this was not recorded in their moving and handling care plan. Nor was the profiling bed mentioned. At times they required a hoist and sling, but apart from the sling size, the type of sling or how this was to be fitted was not referred to in the care plan. This posed the risk of inappropriate moving and handling of people.

Although we observed staff supporting some people to move appropriately we also observed some areas of poor practice in this area during our inspection such as; encouraging a person to pull up on a Zimmer frame to stand, staff not putting the brakes on wheelchairs before encouraging people to stand, and in one case, a person was assisted to transfer using a standing hoist when there was no assessment in place to determine the appropriateness of the equipment or the sling. Poor moving and handling practice poses a risk to the health and welfare of the people living at the home.

We observed one person who was at risk of pressure sores had an airflow cushion for their high seat chair and a pressure mattress for their bed. However, we observed staff did not utilise any pressure cushion for this person whilst they were in their wheelchair or whilst they were eating their meal in the dining area,

which posed a risk to their tissue viability.

At our previous inspection we had been concerned about the security of the front door access and people leaving the premises without the supervision required. The registered provider had put in measures including limiting access to the key code to the inner front door to staff only to ensure people living there did not leave the home without staff knowledge. However, entry into the building was by an outer and inner door which were not locked. On the first day of our inspection a visitor left the building as we entered and the door did not automatically shut and lock, which meant a person living at the home could have left the premises. We raised this with the manager and area manager who agreed to lock the outer door to prevent this from happening which also meant visitors would be required to ring the bell and wait for staff to answer the door. This would also prevent people from entering the building without staff knowledge which would improve safety at the home.

We asked the manager how they determined staffing levels. They told us the registered provider utilised a tool based on guidance published by the Royal College of Nursing which they shared with us. This detailed staffing levels based on occupancy with additional staff required if dependency indicated support was required for example, at mealtimes, or if two care staff were required to assist people with their support needs. The manager advised us there were five staff in attendance in the morning, five in the afternoon and three care staff during the night.

The manager told us staffing levels had been a struggle recently due to staff holidays but they continued to cover any shortfall with their own staff and did not employ agency staff at the home. We asked people at the home whether there were enough staff to meet people's needs promptly. The response was mixed. One person said, "It's buzz, buzz, buzz. Wait, wait, wait." During our inspection we observed call bells were answered promptly.

The registered provider had developed and trained their staff in safeguarding adults from abuse. All the staff we spoke with demonstrated they understood how to ensure people were safeguarded against abuse and they knew the procedure to follow to report any incidents. However, there was a culture of poor risk management at the home, so although staff had been trained in safeguarding people from abuse, the systems and processes were not adequate to support safe care and treatment.

We looked at three staff files for staff that had been recruited since our last inspection. We found all necessary recruitment checks had been made to ensure staff suitability to work in the home. This included a Disclosure and Barring Services (DBS) check, a review of people's employment history and two references received for each person (although they had to obtain a copy of one during our inspection as this was not in the file). The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups.

As part of our inspection process we checked to see whether medicines were ordered, stored and administered safely. We observed a senior member of staff administering medicines. They wore a tabard to identify they should not be disturbed whilst administering medicines. We observed they explained to people what the medicines were for with explanations such as, "This is for your tummy," and "This is for your pain."

The medicines room was well organised and clean. Fridge and room temperatures were taken each day and there was a weekly audit of medication to ensure the amount of medicines tallied with the recorded amount. We saw some 'as and when required' (PRN) medicines were supported by written instructions which described situations and presentations where PRN medicines could be given but this was not the case for all these medicines. The manager agreed to rectify this immediately. At our last inspection we

observed, body maps were not used to direct staff to where to apply creams, and this was still an issue at this inspection. We also noted that eye drops which required to be kept in the fridge were not and they had not been dated upon opening. In addition the home did not utilise pain relieving transdermal patch application records to alert staff to the area patches had been applied to ensure they were rotated as required.

Some prescription medicines contain drugs that are controlled under the misuse of drugs legislation. These medicines are called controlled medicines. We inspected the controlled medicines register and found medicines were accurately recorded and administered in accordance with good practice.

We spoke with a domestic member of staff who told us they had recently changed their shift pattern to ensure domestic staff were available morning and in the afternoon. We found a range of personal protective equipment in the communal bathrooms and toilets. We observed some areas of the home were odorous. For example, one person's mattress and their carpet had a significant malodour as did one person's wheelchair seat which demonstrated the systems in place for ensuring the cleanliness of some equipment had not been effective.

The evidence detailed above demonstrated a continued breach in Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to safe care and treatment.

Is the service effective?

Our findings

At our previous inspection we found a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as lawful consent had not always been sought and the home did not have a record of who had a Lasting Power of Attorney in place. At this inspection we checked to see whether improvements had been made.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. At the time of our inspection, five DoLS applications had been authorised and the registered provider was awaiting the outcome of a further three assessments. 12 applications were outstanding with the local authority in total. The manager was able to tell us who had conditions attached to their authorisations and how these were being met.

The home assessed people against a Deprivation of Liberty check list to determine whether the person had their liberty restricted. This guided the assessor to identify when a person was at risk of having their liberty deprived and when a referral to the authorising body was required. The manager had a good understanding around the assessment of capacity and we overheard them describe to the assistant manager how a person only had to retain the information long enough to make the specific decision. We saw detailed information in the capacity section of people's care files to support people to make their own decisions where people had cognitive impairments, but could make decisions for themselves with support.

The staff at the home had ascertained whether there was a lasting power of attorney (LPA) or a Court of Protection authority for others to consent on behalf of people at the home. A registered Lasting Power of Attorney is a lawful process that allows a nominated person to make decisions on their behalf, including decisions about their health and welfare, if they lose the mental capacity to do so themselves. The manager and administrator had contacted relatives and the Office of the Public Guardian for confirmation as to who had registered their power of attorney. There were issues with staff signing consent on behalf of others at the previous inspection. There had been an improvement in this area but we still found not all consent forms in care files had been signed or removed if no longer appropriate.

We asked people whether they enjoyed their meals at Stella House. One person said, "The food is very good we get two choices at every meal." Another person told us, "They do a nice assortment of foods you have to be very fussy not to like what they bring."

We observed lunch time in the communal dining room. People were seated at tables although we found the layout of some tables did not encourage meal times to be a social event as several people were at tables on their own facing the wall. We observed people were offered clothes protectors to maintain their dignity whilst eating. There was a menu on the wall with the day's choice of meals. People had a choice of two main meals and we observed staff asking people which meal they preferred. For example staff asked, "Would you like chicken or steak?" They also presented both meals plated to assist people to choose. People spoke positively about the food and the choices they had.

The registered provider used an external catering company to supply pre-prepared meals which the kitchen staff reheated. There was a choice of food in stock. The cook advised us, "The quality is good and consistent, but we've gone back to doing our own chips as the residents prefer those." One relative we spoke with told us their relative had lost weight since the new catering company had taken over. We spoke with the manager who told us there had been an issue at the start with some meals being too spicy for people, which prompted a return to more traditional foods such as meat and two vegetables, which people preferred.

People received tea, coffee and biscuits during the inspection and there was a jug of juice in the communal areas and in people's bedrooms. We observed a staff member offer people juice mid-morning in the communal lounge and encourage people to drink. Apart from the biscuits offered to people with the morning and afternoon tea, there were no other snacks available for people to help themselves to or as an encouragement for those who were nutritionally at risk.

People who required their fluid and nutrition intake to be monitored had a food and fluid intake chart. There were gaps in the completion of the records to confirm what people had eaten on the day prior to our second day of inspection for those people who ate in the communal areas. The charts for those people who ate in their bedrooms were kept in their rooms, but had not been completed on the day prior to the second day of our inspection. One person identified at risk of malnutrition and dehydration had only taken 280ml of fluid the day before our inspection, but there was no obvious records in place to demonstrate what additional measures had been attempted to improve their intake that day. Recording information consistently had been an issue at our last inspections, and demonstrated there was a lack of oversight in this aspect of care delivery.

One person who had been seen by the dietician due to weight loss had a recommendation to be offered custard shots to halt their weight loss. However, their care plan had not been updated to reflect this and we saw no evidence they had been offered these shots during our inspection. We were told by a member of staff that one person required a 'soft, blended diet', but their care plan had not been updated to reflect this.

This demonstrated a breach in Regulation 14 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff completed the Care Certificate and the registered provider assessed they had met the standards to complete the certificate. The aim of the Care Certificate is to provide evidence that health or social care support workers have been assessed against a specific set of standards and have demonstrated they have skills, knowledge and behaviours to ensure they provide compassionate and high quality care and support.

The registered provider utilised an external training provider to support staff development and also some training was provided in-house. The training matrix showed us a range of learning opportunities were provided for all staff. Staff were encouraged to attain National Vocational Qualifications at the appropriate level to their role. Staff who administered medicines had their competencies checked by the manager or assistant manager and records of these checks were kept at the home. The assistant manager undertook

the practical moving and handling training and had additional qualifications to undertake this role. We asked them for evidence of the moving and handling practical technical techniques they taught and their assessment of staff competency and they told us they did not record this. We were told at the last inspection this had been introduced. It is important to record the moving and handling techniques demonstrated to staff and to assess their competency formally to ensure they always follow best practice and develop competency in this area.

The manager told us they undertook supervision which should happen every three months in accordance with the registered provider's policy and were contractually obliged to complete four supervisions a year with staff under their local authority contract. They explained they were slightly behind with these sessions but most staff had received supervision in November or December 2016. We saw evidence in supervision records that the importance of accurate recording had been discussed, but we continued to find incomplete care records at the home so a more robust discussion was required to improve the practice of those staff found to be less competent in this area. Staff had received an annual appraisal with the registered provider and the manager told us they would be undertaking staff appraisals going forward.

One person had a specialist seating system in place which was a restriction to their liberty and we saw there had been a capacity assessment and best interest decision in relation to this restriction. We did not see any decision specific capacity assessment in relation to personal care decisions, but they were in place in relation to medicines, deprivations and other restrictions.

A chiropodist attended the home every six to eight weeks and community nurses visited each day to support people with insulin and pressure care. People tended to keep their own dentist and the home offered to take people to appointments, at a charge specified in the service user guide. The manager told us a local dentist had offered free training to the home in relation to oral health and signs of ill-health, but a date had yet to be arranged at the time of inspection. The home was to be provided with the services of the Vanguard Team from April 2017. This dedicated team of health and care professionals' team proactively monitors people to make sure care for potential health problems is offered as early as possible. They support and build the skills and confidence of care home staff through training and education.

The home had ramped access to the front and an enclosed garden to the rear. Access between floors was provided by a through floor lift and stairlift. The home was accessible in a wheelchair although some toilets were not wheelchair accessible.

Is the service caring?

Our findings

People who could voice their opinion told us staff were kind and caring. Comments included, "The girls here are lovely they call me by my first name" and "I'm very happy, they look after me well. I've no worries at all." Another person told us, "I can't speak highly enough about here. The girls are fantastic."

We observed staff were kind and considerate in their interactions with people and they spoke with people calmly and gently. We observed staff were patient and respectful when assisting one person in a hoist. We observed one person who was visibly distressed and the staff member used distraction techniques such as talking about meals and clothing and was polite, understanding and gentle. We observed staff knock on people's doors before entering. They greeted people politely with a "Good morning." Throughout the day we saw staff speak with people in a respectful way. We saw people were appropriately supported with their lunch when required and this was done in a caring and dignified way.

We asked about equality and diversity and how people were supported in relation to their religious and cultural needs. The manager told us they had a monthly church visit. They said, "I don't have anyone here who wants to go to church, but we could accommodate it." Each person had a cultural, spiritual and faith care plan in place. Not all had been completed, but in one person's record the following information was recorded, 'I attempted to have a conversation with [Name] about their faith but the conversation wasn't informative enough. Staff to ensure [Name] is asked they would enjoy joining in the church service when they visit Stella House'.

Staff encouraged people to remain as independent as possible during personal care activities. One relative commented on the support the home had provided to improve their relatives mobility and told us, "They have really helped [relations] walking. When they first came in they could only walk a few steps but now they can walk the full length of the corridor."

No one at the home utilised advocacy services at the time of this inspection. An advocate helps people express their wishes and feelings, supports them in weighing up their options, and assists them in making their own decisions. An Independent Mental Capacity Advocate (IMCA) supports and represents the person in the decision-making process if they lack the capacity to make decisions on their own.

The manager told us they had recently undertaken training from a member of hospice staff in end of life care and care planning. We saw some end of life care plans in the files we reviewed, but there was no plan in two of the care files.

Is the service responsive?

Our findings

At our previous inspection the registered provider had been in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as records relating to the care and treatment of people were not accurate or up to date. At this inspection we checked to see whether improvements had been made and sustained.

Each person who lived at Stella House had a care file which detailed the information to enable staff to care for them. Care plans were locked away in the medication room and only the person responsible for medicines held the key, which meant care staff did not have immediate access to care files. We found staff knew people well and their likes and dislikes but this information was handed out by word of mouth, at handover or by reading daily records which were kept in the staff office. Care files contained care plans with separate sections for each area of care such as nutrition and diet, continence, communication, personal hygiene, mobility and cognition. Assessments cross referenced with relevant risk assessments and recorded the broad goals and aims of the care provision. Some sections were completed well and information was detailed and person centred. However, some information was incorrect. For example, one person's continence care plans referenced they had a catheter, which was no longer in situ at the time of the inspection. There was an evaluation of care which was done monthly or sooner depending on whether needs had changed. The evaluation information contained a more accurate account of people's care needs and contained the information required to care for the person. The discrepancy between evaluations of care and care plans would have been picked up had there been more oversight of care records.

At our last inspection we found an issue with one person who had been staying on a temporary basis and whose care plan had not been completed fully. At this inspection one person who had been on a temporary stay but who had become permanent since 23 January 2017 did not have a full care plan in place. This demonstrated the home had still not put in place effective systems to ensure care plans were completed fully within an acceptable time frame.

We found gaps in the recording of when people had been assisted to bath and shower. For example, in February 2017 only 14 baths or showers had been recorded and up to the time of inspection in March 2017, 32 had been recorded. We brought this to the attention of the manager and area manager who told us they thought this was a recording issue, and people had been assisted to bathe or shower, but there was no evidence provided at the time of the inspection to confirm this, and there had been no oversight of the chart to highlight staff were not recording when people had been assisted to bathe. We also asked the assistant manager what the procedure was for offering people a bath or a shower. They told us "We do a corridor a day. The time of day depends on what is on. It's better in an afternoon as we have a crossover [of staff]. They are asked. When we asked why there were so few recorded in February 2017 they said, "It could be the approach used. People say, "No, I had one yesterday" and the staff don't then encourage people."

The above examples of incomplete and inaccurate records demonstrated a continued breach in Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who lived at Stella House told us they were offered choice in their daily routine. One person said, "I get up when I feel like it, If I want to stay in bed I can." Another person said, "I eat in here (their bedroom) and watch telly." Although when we asked one person what time they got up, they said, "Quarter to six." We asked whether this was from choice, and they told us, "No. I don't mind. I'm used to it now." We observed choice being offered to people through the day including where they wanted to sit to eat, and what they wanted to eat and drink. We saw most bedrooms had been personalised with family photographs, small items of furniture and ornaments.

We asked relatives whether they were involved in decisions about the health and welfare of their relation. One relative told us, "The staff are very friendly and keep us informed." Another said, "[Relative] needed a change of medication recently and they fully discussed it with us." A further relative said, "They never make any decisions without consulting us." However, in contrast one relative told us they were concerned about their relatives care and had not been kept fully informed.

As part of our inspection process, we observed how the registered provider ensured the mental wellbeing of the people who lived at Stella House through the provision of meaningful occupation throughout the day.

Stella House employed an activities co-ordinator, but on the days of inspection as the home was short staffed they were acting as a care worker which meant they were unable to fulfil their activities role. We found them to be passionate and knowledgeable about the importance of meaningful activities. They showed us examples of equipment being sourced for particular residents including making arrangements for the local library to obtain large print books for a person who showed an interest in reading. The mobile library called at the home weekly. A knitting kit had been sourced for two people who enjoyed knitting and we observed one person knitting during our inspection. The activities coordinator had also sourced touch and feel hand mitts for a person who was partially sighted.

The home had an Easter Fayre planned in April 2017 to raise funds for the residents at Stella House. A hairdresser also visited the home every Wednesday. Research into hairdressing from the view of the person living with dementia, their carer workers and their family, published by the Dementia Services Development Centre has shown this type of appearance-related support (visiting a hairdressing salon in a care home) enhances the lives of people with cognitive impairment by enhancing identity, self-expression and social participation. An external provider of armchair exercise also visited the home once a month and the home had a movie evening every Sunday.

We were shown the minutes from the residents meeting held by the activities coordinator on 9 November 2016. Discussions were held about the Halloween party, and arrangements for Christmas events. People's views on the activities which had taken place had been sought and the meeting concluded that further meetings would take place every three months.

The service had a handover meeting between shifts to inform staff on the following shift how the person had been during the previous staff shift to ensure continuity of care. This took 50 minutes on the second day of inspection, which meant there were two staff on the floor supporting people for an extended period. When we asked staff about this, they said if they required a staff member to support they would disturb the meeting.

We were aware of a complaint made by the relative of a person who no longer lived at the home. The manager had been alerted to this by the local authority and was set to commence an investigation into the concerns raised. However, although the complainant told us they had spoken with the home in relation to several of their concerns, not all of this information had made it to the manager to review formally. The

manager had concluded their investigation based on information that had been shared with them.

Is the service well-led?

Our findings

There was no registered manager at the service at the time of this inspection. The previous registered manager had not been working at the service since July 2016 but they had not yet deregistered. A new manager had been appointed and had been at the home at the last inspection in August 2016 on a temporary basis. They told us they had accepted the position of registered manager and would commence the registration process with the Care Quality Commission (CQC). The manager told us they were supported by an area manager. They and another member of staff were undertaking a National Vocational Qualification in management to support their transition in to the management role. They shared their vision with us, "I want it to be a happy environment for residents and staff." They said the current challenges they faced were around staffing and a frequent turnover of people staying at the home such as those waiting for a package of care in the community, or suitable housing. This meant staff were spending time assessing risk and writing care plans for a higher number of people who were only staying for a short amount of time.

Staff spoke highly of the manager and said they had made a difference since they had been in the home and they felt supported. One staff member told us the manager, "Had put a positive spin on the place." However the office was in a separate building at the side of the home, which meant they were not in the building when undertaking the majority of management tasks. The manager told us they involved staff in developments at the home and staff were deployed in specialist areas such as one staff member who led on moving and handling. Another staff member led on infection control and another led on medicines management. They had identified three members of staff to become moving and handling key trainers. Regular staff meetings were no longer happening and the latest meeting for care staff had been held in December 2016, which reduced the opportunity for management to identify matters arising in the home and to detail actions to be undertaken as a result. The manager told us there was no set time frame for staff meetings, but there had been two since they had been at the home. The minutes we saw of the latest meeting in December 2016 showed detailed discussions had been held around the latest CQC report, DoLS, infection control, Healthwatch and other issues. The manager had also held a team leader meeting in December 2016 which showed a detailed discussion had been held with the team leaders and they reflected on areas where improvements were required.

As part of our inspection process we looked to see whether audit and quality assurance systems had been effective in identifying and addressing problems and how the registered provider monitored the quality of their service. The area manager told us they had not completed an overview audit at the service although this was their intention going forwards. They had been acting as a manager at one of their other homes which had no manager, but a new manager had now been appointment, so they intended to address aspects of their role that they had not previously had the capacity to do at Stella House. Some improvements had been made since our last inspection such as the recording of registered Lasting Power of Attorneys to enable staff to determine who had the legal authority to consent on behalf of people at the service and which decisions this related to. Information in some areas of the care plans was detailed and person centred. However, not all areas had made sufficient or sustained improvements. Following the last inspection the manager sent us an action plan advising us care plans would be audited regularly and measures would be put in place to check improvements had been sustained. However, we found there was

no care plan audit in place and although the manager told us they had changed the system so each member of staff completed a section of the care plan in line with their expertise, the fact that we found incorrect information in care plans demonstrated there were still issues with recording people's information.

We found various issues at the home which should have been picked up if there had been robust audits in place. These included recording issues such as gaps in the recording of when people had been assisted to bath and shower, one person did not have a full care plan in place (this was an issue at the last inspection), One person's continence care plans referenced they had a catheter, which was no longer in situ at the time of the inspection, nutritional care plans were not all up to date; moving and handling care plan for one person not up to date and we observed the person was hoisted during the day; audits of medicines had not picked up the same issues as last inspection, namely eye drops not kept in fridge or dated upon opening. In addition body maps not completed or charts for application of patches.

We asked the area manager and home manager how people's weights were monitored and they told us this was done weekly on an individual basis. They told us they did not carry out an overall audit or analysis of people's weight which meant there was no overview of weight loss at the home in order to analyse what was causing this.

The above examples demonstrated a breach in Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

The home undertook monthly medication audits, infection prevention and control monthly audit moving and handling equipment monthly audits (although the last one was completed in December 2016), bedroom audits, and management daily checks (completed weekly). The manager had also completed service user quality assurance management audits which involved a conversation with people using the service and their comments in relation to safe, effective, responsive and well led care. This demonstrated they were seeking the views of people at the home to determine whether improvements were required.

The service recorded all accidents and incidents and these were collated on an accident and incident analysis form. The manager reviewed this information each month to determine any themes. However, on our review, we found a deeper analysis was required with information such as where staff were when the person had fallen to identify whether it was a staff deployment issue. Following our inspection the manager sent us information in relation to falls in March 2017 which had a higher level of information to enable a deeper analysis.

The last annual Stella House Quality assurance was dated June 2016 which was prior to our last inspection. The manager told us questionnaires would be sent out for the 2017 survey imminently. There had been no relative meetings since our last inspection.

The manager had undertaken staff disciplinary processes where the standard of care by staff had fallen below the expected standard which demonstrated the service took measures to ensure staff exhibited behaviours expected of a person caring for vulnerable people.

We checked the maintenance and safety records at the home. Fire safety checks had been completed on the extinguishers and blankets, and staff had been trained in this area. Emergency lighting had been tested, and the fire detection system had been serviced and inspected. The nurse call system had been serviced and maintained and the weighing scales calibrated. The passenger lift and stair lift had been serviced and checked and hoists and slings had been tested against the Lifting and Lowering Equipment Regulations (LOLER). The home had a work programme which listed all repairs or issues that required a response but

there were not always dates against the completion to determine how responsive the service had been, although actions had been certified as completed. The home had commissioned a company to undertake a risk assessment against the risks of Legionella. The report was sent to us following the inspection and the area manager was in the process of completing actions against the recommendations in the report.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Failure to establish safe systems of work to ensure the safety of people living at the home.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs There was a lack of evidence to confirm people had their nutritional and hydration needs met appropriately.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Inaccurate and incomplete care records. Failure to assess, monitor and mitigate the risk in relation to the health, safety and welfare of people Failure to assess, monitor and improve the quality and safety of the services provided.